CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

IDENTIFICATION NUMBER: 155181 NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY IX4 ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFEX HEACH DEPICIENCY MIST BE PERCEIDED BY FULL TAG REQUILATION OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/31/11 and 06/01/11 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Carmel Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety Fone Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 4101AC 16.2. This one story facility with a partial walkout lower level was determined to be of Type V (III) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has a fire alarm system with smoke detection fire facility has a	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA					(X3) DATE		
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CARMEL HEALTH & LIVING COMMUNITY (X4) ID SUMMARY STATEMENT OF DEPRCENCES CARMEL, IN46032 (X5) COMMETION PREFIX (EACH DEPRCENCY MUST BE PRECEDED BY PLL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 05/31/11 and 06/01/11 Facility Number: 000095 Provider Number: 155181 AIM Number: 100290490 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Carmel Health & Living Community was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 LAC 16.2. This one story facility with a partial walkout lower level was determined to be of Type V (111) construction and fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors and in all resident rooms. The facility has					STREET A	ADDRESS, CITY, STATE, ZIP CODE		
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

K1K821

Facility ID:

AND PLAN OF CORRECTION IDEN		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	A. BUILDI		O1	(X3) DATE S COMPL 06/01/20	ETED
	PROVIDER OR SUPPLIER		1	I18 MED	DDRESS, CITY, STATE, ZIP CODE DICAL DRIVE L, IN46032		
(X4) ID PREFIX TAG	(EACH DEFICIENT REGULATORY OR a capacity of 229 at the time of this Quality Review by I Safety Code Special 06/07/11.	Robert Booher, REHS, Life ist-Medical Surveyor on found not in compliance ntioned regulatory	PR	EFIX FAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
K0020 SS=E	shafts, chutes, and between floors are having a fire resist hour. An atrium my with 8.2.5.6. 19. Based on observation facility failed to estairwell opening construction have fire resistance. It vertical opening protected in account LSC 8.2.5.2 states shall be enclosed fire resistance rates 8.2.3.2.1 requires a one hour vertical the Standard for Windows at 2-1.2.	ention and interview, the ensure 2 of 2 vertical as were enclosed with ng at least a one hour SC 19.3.1.1 requires any	K002	20	No residents were affected be alleged deficient practice. Late hardware that allows the door latch and close in the door frames has been installed on stairway doors at the main entrance and by the speech therapy room. All stairway dowill be inspected to assure the latches are equipped. Maintenance supervisor/designee will audi all stairway doors and report administrator/assistant administrator the findings. Latches will be installed as needed. Administrator will review morfor compliance for the next 13	ching rs to the ors eat t to ant othing	07/01/2011

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K1K821

Facility ID:

000095

If continuation sheet

Page 2 of 16

PRINTED: 07/06/2011 FORM APPROVED OMB NO. 0938-0391

	OF CORRECTION	IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	NSTRUCTION	COMPL	
AND PLAN	OF CORRECTION	155181	A. BUI	LDING	01	06/01/2	
		133101	B. WIN			00/01/2	011
NAME OF P	PROVIDER OR SUPPLIER			1	DDRESS, CITY, STATE, ZIP CODE		
CADMEL		COMMUNITY			DICAL DRIVE L, IN46032		
	. HEALTH & LIVING			<u> </u>	L, IN40U3Z		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
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IAG		LSC IDENTIFYING INFORMATION)	+	IAG	months will all findings bein	0	DATE
	•	e doors to be closed and			forwarded to the Quality	9	
		ne of fire. This deficient			Assurance Commitee for re	view	
	•	fect any residents, staff			and further recommendatio	ns will	
		e vicinity of the stairwell			be made as necessary.		
		ntor in the main entrance					
		y of the stairwell door by					
	the speech therap	by room.					
	Findings include	·					
	Based on observa	ation with the Director of					
	Maintenance dur	ing a tour of the facility					
	from 1:00 p.m. t	o 3:15 p.m. on 05/31/11,					
	the stairwell doo	r by the elevator in the					
	main entrance an	d the stairwell door by					
	the speech therap	by room which each lead					
	to the walkout lo	wer level are equipped					
	with magnetic lo	cking devices and self					
	-	out each stairwell door is					
	_	h latching hardware to					
	•	o latch and close in the					
		sed on interview at the					
		on, the Director of					
		nowledged each stairwell					
		ded with latching					
	•	w each door to latch into					
	the door frame.	, such door to luter into					
	ane door manne.						
	3.1-19(b)						
	3.1 17(0)						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	(X2) MULTIPLE C A. BUILDING B. WING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/01/2011
	PROVIDER OR SUPPLIER		118 M	TADDRESS, CITY, STATE, ZIP CODE EDICAL DRIVE IEL, IN46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	(X5) COMPLETION DATE
K0027 SS=E	a 20-minute fire pr least 1¾-inch thick Non-rated protecti 48 inches from the permitted. Horizon with 7.2.1.14. Doc automatic closing 19.2.2.2.6. Swing to swing with egre not required. 19 Based on observational facility failed to a smoke barrier do the kitchen to the restrict the move least 20 minutes. requires doors in comply with LSG Section 8.3.4.1 rebarriers to close the minimum cle proper operation inch to restrict th This deficient praresident, staff or the smoke barrier from the kitchen Findings include Based on observation include	smoke barriers have at least otection rating or are at a solid bonded wood core. We plates that do not exceed a bottom of the door are not alsliding doors comply ors are self-closing or in accordance with ing doors are not required as and positive latching is 1.3.7.5, 19.3.7.6, 19.3.7.7 action and interview, the ensure 1 of 2 sets of ors in the corridor from a 700 South Hall would ment of smoke for at LSC, Section 19.3.7.6 smoke barriers shall a Section 8.3.4. LSC equires doors in smoke the opening leaving only arance necessary for which is defined as 1/8 to the movement of smoke. The actice could affect any visitor in the vicinity of a door set in the corridor to the 700 South Hall.	K0027	No residents were affected be alleged deficient practice. The center hall smoke barrier doe has been adjusted to to ensut that no more than a 1/8 inch is allowed between doors. All smoke barrier doors will be audited by maintenance supervisor/designee monthly ensure that there is no more a 1/8 inch gap upon closure. Administrator/Assist. Administrator will review mor for compliance. The Administrator will submit mor finding for 12 months to the Quality AssuranceCommittee review and further recommendations will be made as necessary.	e or

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

K1K821

Facility ID:

000095

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVE A PHILIPPIC 01 COMPLETED			
ANDILAN	or correction	155181	A. BUILDING		06/01/2011
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	ROVIDER OR SUPPLIER			DICAL DRIVE	
	. HEALTH & LIVING		CARME	EL, IN46032	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	*	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	TE COMPLETION DATE
		center hall smoke barrier			
		npletely, leaving a one			
		ap between the doors.			
	Based on interview	-			
	observation, the	Director of Maintenance			
	stated the door la	tching hardware was			
	dragging on the f	floor and would not allow			
	the door set to cle	ose completely and			
	acknowledged a one and a half inch gap				
between the two doors when the doors were closed.					
	3.1-19(b)				
K0029	One hour fire rated	d construction (with ¾ hour			
SS=E		r an approved automatic fire			
		em in accordance with 8.4.1			
	and/or 19.3.5.4 pro When the approve	otects hazardous areas.			
		em option is used, the areas			
		n other spaces by smoke			
		and doors. Doors are			
		on-rated or field-applied nat do not exceed 48 inches			
		the door are permitted.			
	19.3.2.1	7. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1.	170020	No regidente were effected b	w the 07/01/2011
		ervation and interview,	K0029	No residents were affected balleged deficient practice. Sel	
	=	to ensure 2 of 11 doors		closing devices have been	
	serving hazardou	is areas such as as with natural gas fired		installed on the door of the	710
		pped with self closing		mechanical rooms by room 7 and room 404. A self closing	
	_	oors. This deficient		device will be installed on the	
		fect any resident, staff or		kitchen entry door. The 3	
	r-active coara ar			mechanical rooms with natur	aı

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Event ID:

K1K821

Facility ID:

000095

If continuation sheet

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) M	IULTIPLE CO	NSTRUCTION	(X3) DATE S COMPL		
AND PLAN	OF CORRECTION	155181	A. BUI	LDING	01	06/01/2	
		100101	B. WIN		PRESIDENCE CONTROL CON	00/01/2	011
NAME OF	PROVIDER OR SUPPLIEF	8		1	ADDRESS, CITY, STATE, ZIP CODE DICAL DRIVE		
CARMEI	_ HEALTH & LIVING	COMMUNITY		1	EL, IN46032		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	ICY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ΓE	COMPLETION
TAG	†	LSC IDENTIFYING INFORMATION)	+	TAG	,		DATE
		inity of the mechanical			gas fired furnaces will have positive latching mechanisms	2	
	1	† 719 and the mechanical			installed.All mechanical room		
	room by Room #	‡ 404.			containing a natural gas fired		
	Findings include	:			furnace will have doors inspe by maintenance staff to assu presence of a self closing de	nspected issure	
	Based on observ	ations with the Director			and positive latching mechanisms. The doors to the	10	
	of Maintenance	during the tour of the			kitchen areas will also be	.~	
	facility from 1:0	00 p.m. to 3:15 p.m. on			inspected for presence of se		
	05/31/11 and from 9:00 a.m. to 12:15 p.m.				latching devices. The finding		
	on 06/01/11, the mechanical room by Room # 719 and the mechanical room by				the inspection will be reviewed with the admininstrator/assis		
					administrator monthly.The	lanı	
	Room # 404 eac	h contain one natural gas			administrator/assistant		
	fired furnace and	l are each not equipped			administrator will review mor	-	
		ng device on the entry			for 12 months for compliance		
		interview at the time of			all findings being forwarded t Quality Assurance Committe		
	observation, the	Director of Maintenance			review and further		
		ne entry door to the			recommendations will be ma	de	
	~	n by Room # 719 and the			as needed.		
		mechanical room by					
	· ·	h are not equipped with a					
	self closing devi						
	3.1-19(b)						
	2. Based on obs	ervation and interview,					
		to ensure 1 of 2 doors					
	1	us areas such as the					
	_	ipped with an operable					
	_	ce on the door. This					
	_	e could affect any					
		visitor in the vicinity of					
		door in the corridor to					
	the 700 South H						
	Life / 00 boutil II	W11.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181		(X2) MI A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE S COMPL 06/01/2	ETED	
	ROVIDER OR SUPPLIER		1	STREET A	ADDRESS, CITY, STATE, ZIP CODE DICAL DRIVE EL, IN46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	Ē	(X5) COMPLETION DATE
	Findings include	:					
	Maintenance dur from 1:00 p.m. the kitchen door closing device or bottom hinge self-disconnected from allowed the entry the open position the time observat Maintenance ack not self-closing with removed. 3.1-19(b) 3. Based on obsethe facility failed hazardous areas a rooms with natur provided with pomechanisms. The could affect any the vicinity of the elevator in the mimechanical room the nurses station.	is deficient practice resident, staff or visitor in the mechanical room by the ain entrance, in the ain 800 North, north of a, and in the vicinity of the poom by room # 823.					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155181		(X2) M A. BUII B. WIN	LDING	NSTRUCTION 01	(X3) DATE COMPL	ETED	
	PROVIDER OR SUPPLIER . HEALTH & LIVING		B. WIN	STREET A	DDRESS, CITY, STATE, ZIP CODE DICAL DRIVE EL, IN46032		
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	(X5) COMPLETION DATE
	of Maintenance of facility from 1:0 05/31/11 and from 0 06/01/11, the elevator in the mischanical room the nurses station room by room # natural gas fired mechanical room with a self closin provided with po Based on interview observation, the lacknowledged each	in 800 North, north of a, and the mechanical 823 each contain one furnace and each entry door is provided g device but is not sitive latching hardware. ew at the time of Director of Maintenance ch mechanical room provided with positive					
K0050 SS=F	varying conditions shift. The staff is f is aware that drills routine. Responsi conducting drills is competent person exercise leadershi conducted betwee announcement ma	at unexpected times under at least quarterly on each amiliar with procedures and are part of established bility for planning and assigned only to swho are qualified to p. Where drills are n 9 PM and 6 AM a coded by be used instead of 19.7.1.2					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI	ULTIPLE CO	ONSTRUCTION	(X3) DATE		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	LDING	01	COMPL	
		155181	B. WIN			06/01/2	011
NAME OF F	ROVIDER OR SUPPLIER	L.		l	ADDRESS, CITY, STATE, ZIP CODE EDICAL DRIVE		
CARMEL	HEALTH & LIVING	COMMUNITY		I	EL, IN46032		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		CY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ГЕ	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)	_	DATE
		review and interview, the	K(0050	No residents were affected balleged deficient practice. The		07/01/2011
	facility failed to	ensure fire drills were			Maintenance Surpervisor wil		
	•	erly on the second shift			schedule a fire drill for the m		
	for 1 of 4 quarter	rs. This deficient practice			by the first day of each mont	h and	
	affects all occupa	ants in the facility			inform the administrator of th		
	including resider	nts, staff and visitors.			date and the shift the drill is t	to be	
	Findings include	:			held.The Maintenance Supervisor/designee will ens that all documentation relatir monthly facility fire drill will b	ig to	
	Based on review	of "Fire/Emergency			submitted to the		
		Logbook Documentation"			administrator/designee each		
		of Maintenance from			month. The drills will be conducted on every shift at le	-aet	
		5 p.m. on 05/31/11, there			once per quarter.The	Just	
		tion of a fire drill being			administrator will review mor	nthly	
		e second shift in the			for compliance for the next 1		
	fourth quarter in				months will all findings being forwarded to the Quality		
	-	time of record review, the			Assurance Committee for rev	view	
		tenance stated a fire drill			and further recommendation		
		n the second shift of the			be made as needed.		
		2010 but acknowledged					
	_	nentation of a second					
		ter fire drill available for					
	review.	cer fire drift available for					
	10 V 10 VV .						
	3.1-19(b)						
	3.1-17(0)						
T700/-	Haaties 01.0	a and singer-1991					
K0067 SS=F	comply with the pr are installed in acc manufacturer's sp	ecifications. 19.5.2.1, 9.2,					
	NFPA 90A, 19.5.2 Based on observa	ation and interview, the	K	0067	No residents were affected b	v the	07/01/2011
	Duscu on observe	unon una mici view, the			alleged deficient practice.Life	-	07/01/2011

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155181		A. BUILDING	E CONSTRUCTION 01	i i	E SURVEY PLETED /2011	
	PROVIDER OR SUPPLIER		118	EET ADDRESS, CITY, STATE, 2 MEDICAL DRIVE RMEL, IN46032	I	
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION	ID PREFIX	PROVIDER'S PLAN ((EACH CORRECTIVE ACT CROSS-REFERENCED TC DEFICIEN	TION SHOULD BE O THE APPROPRIATE	(X5) COMPLETION
TAG	facility failed to were not used as system serving a 175 rooms. LSC conditioning, head ductwork and relinstalled in according the Standard for Conditioning and NFPA 90A, 2-3.1 corridors shall not a supply, return, serving adjoining practice could afform staff and visitors. Findings include Based on observed Maintenance durfrom 1:00 p.m. to and from 9:00 a 06/01/11, all resist support offices we corridor as a return based on interview Maintenance durfrom 1:00 p.m. to and from 9:00 a 06/01/11, all resist support offices we corridor as a return based on interview Maintenance durfrom 1:00 p.m. to another the support of the support of the supply air fail located downstreed.	ensure egress corridors a portion of a return air djoining rooms for 175 of 19.5.2.1 requires air ating, ventilating ated equipment to be rdance with NFPA 90A, the Installation of Air d Ventilating Systems. 11.1 requires egress of be used as a portion of or exhaust air system g areas. This deficient fect all of the residents,	TAG	CROSS-REFERENCED TO	ver is being stime. See	DATE

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 155181	A. BUILDING	ONSTRUCTION 01	(X3) DATE SURVEY COMPLETED 06/01/2011
	PROVIDER OR SUPPLIER		118 ME	ADDRESS, CITY, STATE, ZIP CODE EDICAL DRIVE EL, IN46032	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
K0068 SS=E	interconnected to were located to p smoke from one smoke compartments. 3.1-19(b) Combustion and v incinerator and he and discharged to Based on observate facility failed to crooms containing furnaces was procombustion air fit containing fuel from accordance with This deficient praresidents, staff arof the mechanin the 400 Hall. Findings include Based on observation managements are durated from 9:30 a.m. to the mechanical residents are described by the mechanical residents are describ	entilation air for boiler, ater rooms is taken from the outside air. 19.5.2.2 ation and interview, the ensure 1 of 11 utility gnatural gas fired vided with intake rom the outside for rooms ared equipment in LSC Section 19.5.2.2. actice could affect and visitors in the vicinity mical room by room 404	K0068	No residents were affected alleged deficient practice. A air intake unit will be installe the utility room on 400 hall. Maintenance staff will in all utility rooms with natural fired furnaces for the preser intake combustion air from toutside. Administrator vill review mo for compliance for 12 month The findings will be forward the Quality Assurance Comfor review and further recommendations will be mas needed.	fresh d in spect gas ace of he ant nthly s. ed to mittee

Facility ID:

STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	01	COMPL	ETED
		155181	B. WINC			06/01/2	011
					ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER			118 ME	DICAL DRIVE		
	HEALTH & LIVING				EL, IN46032		
(X4) ID		TATEMENT OF DEFICIENCIES	,	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX TAG	`	CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	ſΕ	COMPLETION DATE
1/10	furnace and is no		1	1110			Ditte
		ntake from the outside.					
	Based on interview at the time of						
	observation, the Director of Maintenance acknowledged there is no combustion air						
	_						
		outside supplied to the					
	mechanical room by Room 404 in the 400						
	Hall.						
	3.1-19(b)						
K0143	Transferring of oxy	/gen is:					
SS=E							
	(a) separated from any portion of a facility wherein patients are housed, examined, or						
		ation of a fire barrier of					
	1-hour fire-resistiv						
		is mechanically ventilated,					
	sprinklered, and na flooring; and	as ceramic or concrete					
	nooring, and						
	(c) in an area post	ed with signs indicating that					
		urring, and that smoking in					
	the immediate are accordance with N	a is not permitted in					
	Compressed Gas						
	-	ation and interview, the	K0	143	No residents were affected b	y the	07/01/2011
		ensure 1 of 1 liquid		-	alleged deficient practice.The	e self	· · · · · · · · · · · · · · · · · · ·
	_	reas where transferring of			closing hinges on the one an	da	
		ce was separated from			half hour rated door on the oxygen store room will be		
		facility wherein residents			replaced.All doors requiring self		
		nined, or treated by a			closing devices will be inspected		
		re barrier of 1 hour fire			monthly for proper operation	by	

AND PLAN OF CORRECTION IDENT		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M A. BUII		nstruction 01	(X3) DATE SURVEY COMPLETED		
		155181	B. WIN	G		06/01/2011		
NAME OF PROVIDER OR SUPPLIER CARMEL HEALTH & LIVING COMMUNITY			STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DRIVE CARMEL, IN46032					
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID		(X5)		
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	<u> </u>	TAG	DEFICIENCY)	DATE		
		etion. This deficient			the maintenance staff.The Administrator/Assistant			
	•	fect residents, staff and			nthly			
	visitors in the vicinity of the 300 Hall				Administrator will review more for compliance for the next 1	· 1		
	oxygen storage a	nd transfilling room.			months. The findings will be	:		
	Findings include	:			forwarded to the Quality Assurance Committee for reand further recommendation be made as needed.			
		ation with the Director of						
		ing a tour of the facility						
	from 9:00 a.m. to	•						
		Hall oxygen storage and						
	_	door is a 45 minute rated						
	• •	pped with self closing						
		d latching hardware but						
		evice was rendered						
	•	top hinge pin was						
		oor did not self close and						
		the open position. Based						
		ne time of observation,						
	the Director of M							
	_	e oxygen storage and						
	_	door self closing device						
		s removed and the door						
		and latch into the door						
	frame.							
	3.1-19(b)							
	5.1-17(0)							
K0144 SS=F		spected weekly and ad for 30 minutes per ace with NFPA 99.						

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			l` ´	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155181	A. BUI	LDING	01	. COM 06/01	PLETED /2011
		100101	B. WIN				72011
NAME OF I	PROVIDER OR SUPPLIEF	2		1	ADDRESS, CITY, STATE, ZIP COE DICAL DRIVE	DE .	
CARMEL HEALTH & LIVING COMMUNITY				1	EL, IN46032		
				ID			(V5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHOWN		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		DATE
	Based on reco	ord review and interview,	K(0144	No residents were affe	cted by the	07/01/2011
		to document the load			alleged deficient		
	l -	ne monthly load test for 3			practice.Readings will		
	^	generators for 7 of 12			recorded as a percenta amp load not less than		
		r 3-4.4.1.1 of NFPA 99			of the EPS (Emergency		
	1	testing of generators			Supply) nameplate rati	-	
	1 ^	gency electrical system to			generator has been ad transfer to the emerger		
	_	with NFPA 110. Chapter			generator within 10 sec	•	
		10 requires generator sets			building power		
	in Level 1 and L	evel 2 service to be			loss.The maintenance	414 -11	
	exercised at leas	t once monthly, for a			department will ensure documentation relating		
	minimum of 30 i	minutes, using one of the			testing is completed we		
	following metho	ds:			Maintenance superviso		
	a. Under operatii	ng temperature conditions			will log the time it takes to trans		
	or at not less that	n 30 percent of the EPS			emergency generator power. The Administrator/Assistant		
	(Emergency Pow	ver Supply) nameplate			Adminitrator will	•	
	rating.				review logs monthly for	12	
	b. Loading that r	naintains the minimum			months. Findings will	1:4.	
	exhaust gas temp	peratures as			be reported to the Qua Assurance Committee		
		y the manufacturer.			and further recommend		
		ne of day for required			be made as needed.		
		lecided by the owner,					
		operations. This					
	deficient practice						
	residents, staff a	nd visitors.					
	Findings include						
	Findings include	·•					
	Based on review	of "TELS: Generator I,					
	II, III" document	tation with the Director of					
	Maintenance from	m 9:30 a.m. to 12:15 p.m.					
	on 05/31, month	ly generator load testing					
	documented for	the seven month period					
	from 11/19/10 th	rough 05/23/11 for each					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155181		A. BU	MULTIPLE CO	NSTRUCTION 01	(X3) DATE : COMPL 06/01/2	ETED			
		100101	B. WI				00/01/2	V 1 1		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE 118 MEDICAL DRIVE						
CARMEL HEALTH & LIVING COMMUNITY					L, IN46032					
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S P	LAN OF CORRECTION		(X5)		
PREFIX	`	NCY MUST BE PERCEDED BY FULL		PREFIX	(EACH CORRECTIV CROSS-REFERENCE	E ACTION SHOULD BE ED TO THE APPROPRIATE	.	COMPLETION		
TAG		R LSC IDENTIFYING INFORMATION	D)	TAG	DEF	ICIENCY)		DATE		
	1	emergency generators								
		gency generator ran for at								
	least thirty minu	ites during each								
	documented load	d test but the minimum								
	exhaust gas tem	perature was not recorded								
	and the percenta	age of load capacity was								
	recorded as the	sum of the recorded amps								
	for each phase o	of the three phases for each								
	emergency gene	erator. Based on interview								
	at the time of red	cord review, the Director								
	of Maintenance	acknowledged the facility								
	did not documer	nt the percentage of load								
	capacity for each	h generator on each of the								
		dates and acknowledged								
		khaust gas temperature								
	was not recorded on each of the stated load test dates.									
	load test dates.									
	3.1-19(b)									
	2. Based on record review and interview,									
		d to ensure emergency								
	1	transferred to the								
	1 ^	erator within 10 seconds of	. [
		loss for 2 of 12 months for	I							
		nergency generators.								
		.1.8 states generator sets								
		cient capacity to pick up								
		et the minimum frequency								
		pility requirements of the								
	_	em within 10 seconds after								
	1	ower. NFPA 99, 3-5.4.2								
	_	en record of inspection,								
	_	ercising period and								
FORM CMS-2	2567(02-99) Previous Versi	ions Obsolete Event ID	: K1K82	1 Facility I	D: 000095	If continuation she	eet Pa	ge 15 of 16		

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		155181	A. BUILDING	01	06/01/2011	
			B. WING	ADDRESS, CITY, STATE, ZIP CODE	1 00.0 20	
NAME OF F	PROVIDER OR SUPPLIER			EDICAL DRIVE		
	. HEALTH & LIVING		CARMI	EL, IN46032		
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	`	(EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE	
		egularly maintained and	TAG			
	-	pection by the authority				
	-	on. This deficient				
		fect all residents, staff				
	and visitors.					
	Findings include	:				
	Based on review	of "TELS: Generator I,				
		ation with the Director of				
	· ·	m 9:30 a.m. to 12:15 p.m.				
	on 05/31/11, wee	_				
	documentation for	or the two month period				
	from 04/12/11 to	5/23/11 lists the transfer				
	time as 32 to 37	seconds for emergency				
	_	sed on interview at the				
		view, the Director of				
		ted the transfer time to				
	-	emergency generator II				
	•	esting in April and May				
		and recorded as between distance and acknowledged the				
		greater than 10 seconds.				
	transier time was	s greater than 10 seconds.				
	3.1-19(b)					